

USCSOM-PHR Continuing Medical Education Organization – DISCLOSURE STATEMENT

I. GENERAL INFORMATION

(A) As a provider of Continuing Medical Education accredited by the Accreditation Council for Continuing Medical Education, the USCSOM-PHR CME ORGANIZATION must insure balance, independence, objectivity, and scientific integrity in all of its educational activities. (B) We must also be able to show that everyone who is in a position to control the content of an educational activity has disclosed all relevant financial relationships with any commercial interest to the provider and that any conflicts are resolved.

Title of CME Activity: _____

Date(s): _____ Location: _____

Name: _____

Role in Activity: Planning Committee _____ Moderator _____ Speaker _____ Author _____ Other _____

Title of Presentation(s) (if known): _____

By signing this document, you agree to the following elements as expected of individuals involved in the planning and implementation of educational activities sponsored by the USCSOM-PHR CME Organization. Please check the box at the end of each statement to indicate your agreement. I agree to:

For Planning Committee Members and Moderators

1. Comply with all Standards, Guidelines, Policies and Procedures governing continuing medical education.

For Speakers and Authors

1. Address the specified objectives;
2. Deliver balanced and objective evidence-based content;
3. Present the source and type or level of evidence to participants;
4. Discuss all reasonable clinical alternatives when making practice recommendations;
5. Disclose off-label /investigative uses of commercial products/devices.

II. DISCLOSURE

Relevant financial relationships create actual conflicts of interest in CME when individuals have both a financial relationship with a commercial interest and the opportunity to affect the content of CME regarding products or services of that commercial interest. Therefore, have you (or your spouse/partner) had a relevant financial relationship in the past 12 months with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients with the exemption of non-profit or government organizations and non-health care related companies?

A. If you have no relevant relationships please sign and date below.

Signature Date

B. If you do have relevant relationships/affiliations please disclose them and sign and date the form below.

Commercial Interest	Nature of Relevant Financial Relationship
Name of Company PLEASE PRINT	Employee, Grants/Research Support recipient, Board Member, Advisor or Review Panel member, Consultant, Independent Contractor, Stock Shareholder (excluding mutual funds), Speakers' Bureau, Honorarium recipient, Royalty recipient, Holder of Intellectual Property Rights, or Other
1.	
2.	
3.	
4.	
5.	
6.	

Therefore, in light of the relationships/affiliations you designated, **WE ASK THAT YOU ATTEST to the following:**

1. These relationships/affiliations will not bias or otherwise influence my involvement in the activity;
2. Practice recommendations I make relevant to the companies with whom I have relationships/affiliations will be supported by the best available evidence or, absent evidence, will be consistent with generally accepted medical practice.
3. I will comply with the listed elements as outlined in Section I above, and will submit the required documentation within the required timeframe(s).
4. I understand that if I have a perceived or real conflict of interest, the Office of CME will initiate a process to resolve the conflict, including the peer review of my material for the presentation.

Signature Date